A.R.T Patient Intake Form

Name_____ Date of Birth_____

Address_____

Phone/Primary_____ Cell_____

Email_____

Emergency Contact_____ Phone_____

Allergies_____

Describe dietary intake_____

Prescription Medications_____

_____

Diagnosed Medical Conditions_____

_____

_____

Have you had an organ or gland removed? _____

Do you have metal in your body (joint replacements, screws, plates, rods, staples, titanium tooth implants, dental metals, piercings) or clothing? _____

_____

Do you have any implanted medical devices? (pacemaker, defibrillator, glucose monitor, insulin pump)

_____

History of surgery_____

_____

Are you pregnant or breastfeeding? _____ / Do you have a seizure disorder? _____

Do you have cardiac or circulatory problems? _____

List current chief complains and symptoms _____

_____

Personal Responsibility Statement: I have addressed the above information to the best of my knowledge and agree to inform my practitioner of any change in my medical profile including changes in medication. I understand that cancellations are requested 48 hours prior to the scheduled appointment time.

Signature _____ Date _____

Please document the locations of surgical sites, scars, injury sites, tattoos, jewelry/glasses/watch worn frequently.